FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041798

Facility Name: Heartland Health Care Center-Canton

Address: 2081 North Main Street (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: (309) 647-6135 **Fax #** (309) 647-6141

HFS ID Number: 344402510002

Date of Initial License for Current Owners: 09/19/1988

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Deknay, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice President of Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	16	Sheltered Care (SC)	16	5,840	5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	315	13,786	5,967	20,068	8
9	SNF/PED					9
10	ICF	6,551			6,551	10
11	ICF/DD					11
12	SC		1,663		1,663	12
13	DD 16 OR LESS					13
14	TOTALS	6,866	15,449	5,967	28,282	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.07%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/26/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1983 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 82 and days of care provided 4,793

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	171,763	12,358	13,648	197,769	1,868	199,637		199,637			1
2	Food Purchase		167,863		167,863		167,863	(1,348)	166,515			2
3	Housekeeping	94,567	16,399	3,011	113,977		113,977		113,977			3
4	Laundry	33,142	9,518	3,310	45,970		45,970		45,970			4
5	Heat and Other Utilities			97,074	97,074	3,779	100,853	(4,873)	95,980			5
6	Maintenance	36,767	15,632	59,028	111,427		111,427		111,427			6
7	Other (specify):* **Med Waste**			589	589		589		589			7
8	**TOTAL General Services**	336,239	221,770	176,660	734,669	5,647	740,316	(6,221)	734,095			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,430,992	89,881	44,953	1,565,826	6,780	1,572,606	(20,269)	1,552,337			10
10a	Therapy	9,933	9,791	309,315	329,039		329,039		329,039			10a
11	Activities	39,846	5,217	1,285	46,348		46,348		46,348			11
12	Social Services	67,254	128		67,382		67,382		67,382			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,548,025	105,017	370,553	2,023,595	6,780	2,030,375	(20,269)	2,010,106			16
	C. General Administration											
17	Administrative	71,101		227,438	298,539	(51,267)	247,272		247,272			17
18	Directors Fees											18
19	Professional Services			135	135		135	(135)				19
20	Dues, Fees, Subscriptions & Promotions			79,845	79,845		79,845	(63,266)	16,579			20
21	Clerical & General Office Expenses	123,866	42,801	17,021	183,688		183,688	(3,024)	180,664			21
22	Employee Benefits & Payroll Taxes			439,217	439,217	28,172	467,389		467,389			22
23	Inservice Training & Education			724	724		724		724			23
24	Travel and Seminar			13,428	13,428		13,428		13,428			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,960	90,960		90,960		90,960			26
27	Other (specify):* **Personal Purch**			338	338		338	(338)				27
28	**TOTAL General Administration**	194,967	42,801	869,106	1,106,874	(23,095)	1,083,779	(66,763)	1,017,016			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,079,231	369,588	1,416,319	3,865,138	(10,668)	3,854,470	(93,253)	3,761,217			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Health Care Center-Canton #0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			201,020	201,020	10,668	211,688		211,688			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,100	5,100		5,100		5,100			32
33	Real Estate Taxes			64,285	64,285		64,285	24	64,309			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,354	29,354		29,354		29,354			35
36	Other (specify):*											36
37	**TOTAL Ownership**			299,759	299,759	10,668	310,427	24	310,451			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138,509	24,633	163,142		163,142		163,142			39
40	Barber and Beauty Shops			9,373	9,373		9,373		9,373			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,895	44,895		44,895		44,895			42
43	Other (specify):* IV Therapy		1,790		1,790		1,790		1,790			43
44	**TOTAL Special Cost Centers**		140,299	78,901	219,200		219,200		219,200			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,079,231	509,887	1,794,979	4,384,097		4,384,097	(93,229)	4,290,868			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,348)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,873)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,637)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(20,269)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(30)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(135)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,359)	21		24
25	Fund Raising, Advertising and Promotional	(63,266)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	24	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(338)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,229)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (93,229)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heartland Health Care Center-Canton

ID# **0041798**

Report Period Beginning: **01/01/2005**

Ending: **12/31/2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Personal Purchases	$ (338)	27	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(338)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,348)	0	0	0	0	0	0	0	0	0	0	(1,348)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,873)	0	0	0	0	0	0	0	0	0	0	(4,873)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,221)	0	0	0	0	0	0	0	0	0	0	(6,221)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(20,269)	0	0	0	0	0	0	0	0	0	0	(20,269)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(20,269)	0	0	0	0	0	0	0	0	0	0	(20,269)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(135)	0	0	0	0	0	0	0	0	0	0	(135)	19
20	Fees, Subscriptions & Promotions	(63,266)	0	0	0	0	0	0	0	0	0	0	(63,266)	20
21	Clerical & General Office Expenses	(3,024)	0	0	0	0	0	0	0	0	0	0	(3,024)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(338)	0	0	0	0	0	0	0	0	0	0	(338)	27
28	**TOTAL General Administration**	(66,763)	0	0	0	0	0	0	0	0	0	0	(66,763)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(93,253)	0	0	0	0	0	0	0	0	0	0	(93,253)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Heartland Health Care Center-Canton **#** 0041798 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	24	0	0	0	0	0	0	0	0	0	0	24	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	24	0	0	0	0	0	0	0	0	0	0	24	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,229)	0	0	0	0	0	0	0	0	0	0	(93,229)	45

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc	100	Health Care & Retirement Corporation	Toledo, OH			
		of America				
		(See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 227,438	HCR Manor Care, Inc	100.00%	$ 227,438	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	7,083	Heartland Management Services	100.00%	7,083		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 234,521			$ 234,521	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	$ 1,107,111	$ 591,572	4,221,024	$ 1,868	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			4,221,024	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	267,575		4,221,024	451	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		4,221,024	3,328	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	4,221,024	1,301	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,944,092	2,235,491	4,221,024	5,479	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,792,565	22,717,176	4,221,024	41,829	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,702,974	43,044,715	4,221,024	134,342	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		4,221,024	10,736	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,855		4,221,024	17,436	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			4,221,024	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		4,221,024	10,668	12
13										13
14	32	Interest								14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 156,575,224	$ 69,154,917		$ 227,438	25

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City Bank, Trustee		X	Finance Capital Additions	N/A		$ 81,675	$ 81,675			$ 5,100	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 81,675	$ 81,675			$ 5,100	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 81,675	$ 81,675			$ 5,100	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	64,261	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	64,285	2
3. Under or (over) accrual (line 2 minus line 1).	$	24	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	64,285	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	64,309	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	55,103	8
	2001	56,741	9
	2002	57,972	10
	2003	61,246	11
	2004	64,285	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Health Care Center-Canton COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0041798

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-15-205-007	See Attached	$ 64,284.66	$ 64,284.66
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,284.66	$ 64,284.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,529 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 55,973	1
2					2
3	TOTALS			$ 55,973	3

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1988	1988	$ 1,936,360	$ 63,427		$ 63,427	$	$ 1,141,603	4
5	AUDIT ADJ 7/1/03 (#1)			1988	(1,508)						5
6				1994	8,975						6
7											7
8											8
	Improvement Type**										
9	Land Improvements (Current Year Depreciation)					78,158		78,158		615,106	9
10	Site Work			1988	125,431						10
11	Sewer & Water Lines			1988	85,093						11
12	Paving			1988	82,940						12
13	Yew Trees			1991	4,440						13
14	Landscaping - Stone Wall			1992	3,812						14
15	Drain Tiles and Catch Basins			1992	7,550						15
16	AUDIT ADJ 7/1/03 (#2) - Drain Tiles			1992	(45)						16
17	AUDIT ADJ 7/1/03 (#2) -Reverse Adjustment			1992	45						17
18	Credit on Land Imp-CNCLD Retainer			1992	(755)						18
19	Fire Rated Door - Staff Development			1992	2,444						19
20	Plumbing - Mixing Valve			1992	676						20
21	Carpeting			1992	5,804						21
22	AUDIT ADJ 7/1/03 (#3) - Carpeting			1992	(5,804)						22
23	Carpet Vestibule Lounge - AUDIT ADJ 7/1/03 (#4) - CHG YEAR			1992	5,804						23
24	Renovation (Moved from CIP in 1995)			1993	5,360						24
25	Electrical (Moved from CIP in 1995)			1993	1,748						25
26	Aluminum Awning			1993	1,376						26
27	Wood Fence for Courtyard			1993	1,785						27
28	Replace Sod			1993	2,575						28
29	Seal & Stripe Parking Lot			1994	7,564						29
30	Painting			1994	994						30
31	Interior DR Remodel, Carpentry			1994	8,650						31
32	Elec, Plumb, DR Remodel			1994	5,130						32
33	Sprinkler Sys			1994	1,193						33
34	Carpet Lobby, Offices, Nurses Station			1994	13,908						34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Concrete Sidewalk	1995	4,440						38
39	Fencing	1995	1,732						39
40	Vinyl Flooring	1995	949						40
41	Electrical	1995	1,154						41
42	Cabinets in Alzheimers Unit	1995	1,394						42
43	Counter Top	1995	244						43
44	Doors	1995	7,346						44
45	Architectural Fees A/L Lounge Renovation	1995	2,231						45
46	Electrical Engineering and Architectural Service Fees-CHG YR	1995	9,766						46
47	Carpet	1996	181						47
48	Painting	1996	1,750						48
49	Painting	1996	1,806						49
50	Labor, Material, Permits to Renovate A/L Lounge	1996	5,615						50
51	Carpeting	1996	1,060						51
52	(51) Doors	1996	8,278						52
53	Grilles for Sliding Glass Door for A/L Lounge	1996	181						53
54	Credit on BLD IMP- CNCLD Retainer	1996	(18)						54
55	Ceramic Tile	1996	3,511						55
56	Painting	1997	148						56
57	Architectural Services	1997	375						57
58	Architectural Services -Alzheimers Unit	1997	2,075						58
59	Additional Architectural Services	1997	500						59
60	Architectural Services - Alzheimers Unit	1997	575						60
61	Addl't HVAC Cost	1997	232						61
62	Architectural Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	3,725						62
63	Engineering Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	250						63
64	Construction Overhead and Interest-AUDIT ADJ 7/1/03 (#7) CHG	1997	18,034						64
65	HVAC - AUDIT AJD 7/1/03 (#7) CHG YEAR	1997	194,747						65
66	Lift Station - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	25,000						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,608,827	$ 141,585		$ 141,585	$	$ 1,756,709	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,608,827	$ 141,585		$ 141,585	$	$ 1,756,709	1
2	HVAC	1998	35,458						2
3	A/C DESIGN & INSTALLATION	1998	36,185						3
4	AA ON ROOFTOP UNIT	1998	7,360						4
5	ROOF TOP UNIT	1998	11,100						5
6	FACIA BOARD & GUTTERS	1998	13,000						6
7	Asphalt Paving	1998	17,441						7
8	INSTALL HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,475						8
9	INSTALL DAMPER HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	643						9
10	INSTALL RTU HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,200						10
11	WALLCOVERINGS	1999	5,319						11
12	CONSTRUCTION OVERHEAD	1999	11,221						12
13	AUDIT ADJ 7/1/03 (#8) - OVERHEAD	1999	(11,221)						13
14	WALLCOVERINGS	1999	4,097						14
15	AUDIT ADJ 7/1/03 (#9) - WALLCOVERINGS	1999	(225)						15
16	SECURE CARE LOCKING SYSTEM	1999	5,101						16
17	PARTITIONS	1999	738						17
18	WALLCOVERINGS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	1,233						18
19	CORNER GUARDS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	251						19
20	COVE BASE-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	539						20
21	LOREN COOK ROOF EXHAUST-AUDIT ADJ 7/1/03 (#10) CHG	1999	1,325						21
22	WALL VINYL COVERING	1999	1,936						22
23	CABINETS & TOPS	1999	5,247						23
24	PAINTING	1999	1,450						24
25	PAINTING	1999	17,000						25
26	AUDIT ADJ 7/1/03 (#11) - PAINTING	1999	(17,000)						26
27	FLOORING - COVE BASE	1999	1,258						27
28	CUSTOM CABINETS	1999	5,820						28
29	PAINTING	1999	15,000						29
30	CEILING INSTALLATION-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1999	10,367						30
31	AUDIT ADJ 7/1/03 (#13) - CEILING INSULATION	1999	(10,367)						31
32	DESIGN FEES FOR ALZHEIMERS UNIT	1999	1,050						32
33	DESIGN FEES FOR ALZHEIMERS UNIT	1999	(1,050)						33
34	TOTAL (lines 1 thru 33)		$ 2,781,779	$ 141,585		$ 141,585	$	$ 1,756,709	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,781,779	$ 141,585		$ 141,585	$	$ 1,756,709	1
2	WALLCOVERING	1999	132						2
3	WALLCOVERING	1999	116						3
4	WALLCOVERING	1999	496						4
5	COOLER	1999	1,245						5
6	AUDIT ADJ 7/1/03 (#14) - COOLER	1999	(1,245)						6
7	WALLCOVERING	1999	744						7
8	AUDIT ADJ 7/1/03 (#15) - WALLCOVERING	1999	(744)						8
9	PAINTING	1999	33,450						9
10	AUDIT ADJ 7/1/03 (#16) - PAINTING	1999	(33,450)						10
11	CABINETRY & COUNTERTOPS	1999	11,067						11
12	AUDIT ADJ 7/1/03 (#17) - CABINETRY	1999	(11,067)						12
13	CARPETING & FLOORING	1999	1,258						13
14	AUDIT ADJ 7/1/03 (#18) - CARPETING	1999	(1,258)						14
15	HVAC	1999	3,318						15
16	AUDIT ADJ 7/1/03 (#19) - HVAC	1999	(3,318)						16
17	CEILING INSTALLATION	1999	10,367						17
18	AUDIT ADJ 7/1/03 (#20) - CEILING INSTALLATION	1999	(10,367)						18
19	FLOORING	2000	24,374						19
20	CONSTRUCTION OVERHEAD AND INTEREST	2000	31,653						20
21	AUDIT ADJ 7/1/03 (#21) - CONSTRUCTION	2000	(31,653)						21
22	DOOR HOLDERS	2000	1,623						22
23	FLOOR COVERING	2000	1,495						23
24	DRY SPRINKLER SYSTEM	2000	1,381						24
25	DRYWALL	2000	6,160						25
26	FREIGHT ON FABRIC	2001	534						26
27	FURNISH & INSTALL HANDRAILS	2001	943						27
28	DOORS	2001	4,200						28
29	ROOF	2001	13,000						29
30	COVE BASE	2001	5,885						30
31	AUDIT ADJ 7/1/03 (# 26) - COVE BASE	2001	(5,885)						31
32	RESIDENT ROOM PAINTING	2002	4,484						32
33	AUDIT ADJ 7/1/03 (# 27) - RESIDENT ROOM PAINTING	2002	(4,484)						33
34	TOTAL (lines 1 thru 33)		$ 2,836,234	$ 141,585		$ 141,585	$	$ 1,756,709	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,836,234	$ 141,585		$ 141,585	$	$ 1,756,709	1
2	RESIDENT ROOM PAINTING	2002	38,492						2
3	AUDIT ADJ 7/1/03 (#22) - PAINTING	2002	(2,814)						3
4	DOORS	2002	3,225						4
5	GENERAL CONSTRUCTION	2002	9,542						5
6	RENOVATION ELECTRICAL-AUDIT ADJ 7/1/03 (#24) CHG YE	2002	61,600						6
7	AUDIT ADJ 7/1/03 (#23) - RENOVATION ELECTRICAL	2002	(2,284)						7
8	STAINLESS STEEL VWC	2002	9,059						8
9	STAINLESS STEEL VWC	2002	1,007						9
10	ROOF	2003	17,781						10
11	ROOF	2003	970						11
12	ROOFING & SHEET METAL	2003	53,562						12
13	GENERAL CONSTRUCTION	2003	3,994						13
14	AUDIT ADJ 7/1/03 (#25) - GENERAL CONSTRUCTION	2003	(3,994)						14
15	CARPET AND INSTALL	2003	22,469						15
16	PAVING	2003	72,546						16
17	OVERHEAD & INTEREST	2003	8,586						17
18	AUDIT ADJ 12/03 (#1) OVERHEAD & INT	2003	(8,586)						18
19	AUDIT ADJ 7/1/03 (#5) - PG 12A LINE 47 + PG 12A LINE 55	2003	(2)						19
20	AUDIT ADJ 7/1/03 (#5) - REVERSAL	2003	2						20
21	CEILING	2004	1,817						21
22	WINDOW	2004	3,078						22
23	DOOR	2004	1,600						23
24	SHEET VINYL FLOORING	2004	7,250						24
25	CUSTOM CABINETS	2004	2,354						25
26	VCT AND COVE BASE	2004	2,250						26
27	ARCH & ENGINEERING COSTS	2005	2,420						27
28	ARCH & ENGINEERING COSTS	2005	423						28
29	HANDRAIL AND BACKER	2005	27,820						29
30	MAGNETIC DOOR	2005	2,515						30
31	METAL DOORS	2005	2,485						31
32	DOOR FRAMES	2005	24,900						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,200,302	$ 141,585		$ 141,585	$	$ 1,756,709	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,025,185	$ 59,435	$ 59,435	$		$ 826,771	71
72	Current Year Purchases	81,724						72
73	Fully Depreciated Assets							73
74	H/O Allocation			10,668	10,668			74
75	TOTALS	$ 1,106,909	$ 59,435	$ 70,103	$ 10,668		$ 826,771	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,363,184	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,020	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 211,688	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,668	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,583,480	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 250,572	92
93			93
94			94
95		$ 250,572	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 29,354 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect Beds, Etc
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	204	hrs	$ 5,396	4,605	$ 115,138	$ 783	4,809	$ 121,317	1
2	Licensed Speech and Language Development Therapist	10a		hrs	(200)	3,167	79,166	164	3,167	79,130	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	179	hrs	4,737	4,600	115,011	8,844	4,779	128,592	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				138,509		138,509	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S-Lab,X-Ray,Inhal	10,Col3, 39					24,633			24,633	13
14	TOTAL				$ 9,933	12,372	$ 333,948	$ 148,300	12,755	$ 492,181	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heartland Health Care Center-Canton **#** 0041798 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,377	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (38,607))	498,275		3
4	Supply Inventory (priced at)	26,163		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,143		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 538,958	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,973		13
14	Buildings, at Historical Cost	3,200,301		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,106,909		16
17	Accumulated Depreciation (book methods)	(2,583,481)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	250,572		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,030,274	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,569,232	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 24,170	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,586		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,285		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	41,110		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 315,151	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,675		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 81,675	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 396,826	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,172,406	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,569,232	$	48

***(See instructions.)**

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,980,291	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,980,291	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	620,586	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 620,586	17	
	B. Transfers (Itemize):			
18	**Change in Interdivision**	(428,471)	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (428,471)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,172,406	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,338,889	1
2	Discounts and Allowances for all Levels	(364,005)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,974,884	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	817,189	6
7	Oxygen	5	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 817,194	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	302	12
13	Barber and Beauty Care	12,726	13
14	Non-Patient Meals	548	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	186,947	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,907	19
20	Radiology and X-Ray	2,177	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 212,607	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purch Discount	(2)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,004,683	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	734,669	31
32	Health Care	2,023,595	32
33	General Administration	1,106,874	33
	B. Capital Expense		
34	Ownership	299,759	34
	C. Ancillary Expense		
35	Special Cost Centers	219,200	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,384,097	40
41	**Income before Income Taxes (line 30 minus line 40)****	620,586	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 620,586	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,479	1,609	$ 45,044	$ 28.00	1
2	Assistant Director of Nursing	2,071	2,253	59,465	26.39	2
3	Registered Nurses	12,346	13,430	286,506	21.33	3
4	Licensed Practical Nurses	17,134	18,638	378,603	20.31	4
5	CNAs & Orderlies	59,132	64,322	631,076	9.81	5
6	CNA Trainees					6
7	Licensed Therapist	340	375	9,933	26.49	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,459	3,749	39,846	10.63	10
11	Social Service Workers	3,819	4,161	67,254	16.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,396	20,055	171,763	8.56	15
16	Dishwashers					16
17	Maintenance Workers	1,884	2,051	36,767	17.93	17
18	Housekeepers	10,189	11,086	94,567	8.53	18
19	Laundry	4,480	4,875	33,142	6.80	19
20	Administrator	2,332	2,332	71,101	30.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,222	9,447	123,866	13.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,283	3,578	30,298	8.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,566	161,961	$ 2,079,231 *	$ 12.84	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	15,000	Line 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Pate	Administrator	0	$ 55,245
John M Ross	Administrator	0	15,856
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,101

B. Administrative - Other

Description	Amount
Home Office	$ 227,438
TOTAL (agree to Schedule V, line 17, col. 3)	$ 227,438
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Claudon, Kost, Barnhart	Legal	135
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 135

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,625
Unemployment Compensation Insurance	43,626
FICA Taxes	150,616
Employee Health Insurance	171,652
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	9,593
401K	8,510
Tuition Program	244
Employee Uniforms	5,350
Payroll Overhead Allocation	1
Home Office Allocation	28,172
TOTAL (agree to Schedule V, line 22, col.8)	$ 467,389

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,025
Advertising: Employee Recruitment	2,956
Health Care Worker Background Check	
(Indicate # of checks performed 179)	3,576
Dues & Subscriptions	751
Association Dues	5,468
Advertising	65,069
Less: Non-Allowable Association Dues	(1,803)
Less: Public Relations Expense	( )
Non-allowable advertising	(61,463)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,579

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Includes travel expense to the Home	13,368
Office in Toledo, OH for regional	
meeting	
Seminar Expense	60
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,428

**See instructions.

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heartland Health Care Center-Canton # 0041798 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 5,469**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $ 1,803**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,199** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **44,895**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(548)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.